

471-000-48 Instructions for Completing "MDS 2.0 Resident Assessment Protocol Summary Form"

USE: The form "MDS 2.0 Resident Assessment Protocol Summary Form" (previously identified as Form MC-76PS) is a mandatory form and must be completed after each full Assessment. The Resident Assessment Protocol Guidelines are described in detail in the HCFA Long Term Care Resident Assessment Instrument User's Manual Version 2.0 10/95. After reviewing triggered RAPs, the RAP Summary form is used to document decisions about care planning and to specify where key information from the assessment for triggered RAP conditions is noted in the record.

REV. AUGUST 15, 2002
MANUAL LETTER # 49-2002

NEBRASKA HHS FINANCE
AND SUPPORT MANUAL

NMAP SERVICES
471-000-48
Page 1 of 2

SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY

Numeric Identifier _____

Resident's Name:		Medical Record No.:	
<p>1. Check if RAP is triggered.</p> <p>2. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status.</p> <ul style="list-style-type: none"> Describe: <ul style="list-style-type: none"> Nature of the condition (may include presence or lack of objective data and subjective complaints). Complications and risk factors that affect your decision to proceed to care planning. Factors that must be considered in developing individualized care plan interventions. Need for referrals/further evaluation by appropriate health professionals. Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident. Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.). <p>3. Indicate under the <u>Location of RAP Assessment Documentation</u> column where information related to the RAP assessment can be found.</p> <p>4. For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and RAPs).</p>			
A. RAP PROBLEM AREA	(a) Check if triggered	Location and Date of RAP Assessment Documentation	(b) Care Planning Decision—check if addressed in care plan
1. DELIRIUM	<input type="checkbox"/>		<input type="checkbox"/>
2. COGNITIVE LOSS	<input type="checkbox"/>		<input type="checkbox"/>
3. VISUAL FUNCTION	<input type="checkbox"/>		<input type="checkbox"/>
4. COMMUNICATION	<input type="checkbox"/>		<input type="checkbox"/>
5. ADL FUNCTIONAL/REHABILITATION POTENTIAL	<input type="checkbox"/>		<input type="checkbox"/>
6. URINARY INCONTINENCE AND INDWELLING CATHETER	<input type="checkbox"/>		<input type="checkbox"/>
7. PSYCHOSOCIAL WELL-BEING	<input type="checkbox"/>		<input type="checkbox"/>
8. MOOD STATE	<input type="checkbox"/>		<input type="checkbox"/>
9. BEHAVIORAL SYMPTOMS	<input type="checkbox"/>		<input type="checkbox"/>
10. ACTIVITIES	<input type="checkbox"/>		<input type="checkbox"/>
11. FALLS	<input type="checkbox"/>		<input type="checkbox"/>
12. NUTRITIONAL STATUS	<input type="checkbox"/>		<input type="checkbox"/>
13. FEEDING TUBES	<input type="checkbox"/>		<input type="checkbox"/>
14. DEHYDRATION/FLUID MAINTENANCE	<input type="checkbox"/>		<input type="checkbox"/>
15. DENTAL CARE	<input type="checkbox"/>		<input type="checkbox"/>
16. PRESSURE ULCERS	<input type="checkbox"/>		<input type="checkbox"/>
17. PSYCHOTROPIC DRUG USE	<input type="checkbox"/>		<input type="checkbox"/>
18. PHYSICAL RESTRAINTS	<input type="checkbox"/>		<input type="checkbox"/>

B. _____
1. Signature of RN Coordinator for RAP Assessment Process

3. Signature of Person Completing Care Planning Decision

2. --
Month Day Year
4. --
Month Day Year